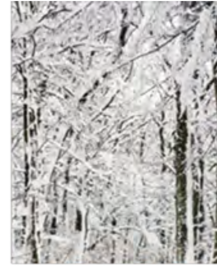

Katherine Latter Counseling, PC —*seeing you through the seasons of your life*

FAMILY BACKGROUND INFORMATION FORM—ADOLESCENT (12-17)

This form is to provide detailed personal history information about you and your history so your therapist can better serve you. Please complete the following information thoroughly. This form is confidential and will be securely maintained as part of your clinical file.

CLIENT INFORMATION

Today's Date: ______________ Date of First Session: ______________

Full Name:			Preferred Name:
Date of Birth:	Age:	Gender: ☐ Male ☐ Female ☐ Other:	
Preferred Pronoun: ☐ He ☐ She ☐ Other:			
Race/Ethnic Origin:		Religious Preference:	
School:			Grade:
CONTACT INFORMATION			
Address:			
City:		State:	Zip Code:
PHONE	Home Phone:	☐ OK to leave message	
	Cell Phone:	☐ OK to leave message ☐ TEXT reminder OK	
EMERGENCY CONTACT INFORMATION			
Name:	Relationship:	Phone:	

Please Share electronic communication (Facebook, Twitter, Snapchat, Instagram, etc.) that you use:

____

Do your parents have access to your electronic communication? ☐ Yes ☐ No

IF NO—please explain: ____

____

Do they have any issues with your use of phone, text, electronic communication? ☐ Yes ☐ No

IF YES—please explain: ____

____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

(Please list **all** immediate family members and, if additional space is needed, please list on back of form)

Name	Relationship (parent, sibling, etc.)	Age	Sex/ Gender	Type (bio, step, etc.)	Living With You
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem that has brought you in for counseling: ______________________

____

How long have these issues been troubling you? ______________________

Are there situations that cause the issues to get worse? ☐ Yes ☐ No — IF YES, please describe:

____

Are there situations that cause the symptoms to improve/subside? ☐ Yes ☐ No — IF YES, please describe:

____

What would you like to see happen as a result of counseling? ______________________

____

Is there any crises in your life right now (danger, family reunions, tests, death, etc.): ☐ Yes ☐ No

IF YES—please list: ______________________

____

COUNSELING / MEDICAL HISTORY

Have you previously seen a counselor? ☐ Yes ☐ No

IF YES: Where and with whom? ______________________

Approximate dates of counseling: ______________________

For what reason did you go to counseling? ______________________

What did you find **most helpful** in therapy? ______________________

____

What did you find **least helpful** in therapy? ______________________

____

Do you have a previous mental health diagnosis / learning disability? ☐ Yes ☐ No

IF YES—please explain: ______________________

Have you ever been psychologically tested? ☐ Yes ☐ No

IF YES—please explain: ____________________

Have you ever used psychiatric services? ☐ Yes ☐ No

IF YES: Where and with whom? ____________________

Approximate dates of counseling: ____________________

IF YES—Was it helpful? ☐ Yes ☐ No

Have you ever taken medication for a mental health concern? ☐ Yes ☐ No

IF YES—please explain: ____________________

Please list below the name of medication, dates taken and its effectiveness.

Name of Medication	Dates Taken	Prescribing Physician	Was it helpful ?
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

Do you seek alternative health care outside of your parents knowledge? ☐ Yes ☐ No

IF YES—please explain: ____________________

Current physician: ____________________ Phone: __________

Hospital: ____________________

Address: ____________________

Date of last medical exam: __________

If female, what are your menstrual cycles like? ____________________

If female, are you on any form of birth control? ☐ Yes ☐ No — IF YES, please explain: __________

____

Have you ever had a head injury? ☐ Yes ☐ No — IF YES, please explain: __________

____

Have you ever been hospitalized? ☐ Yes ☐ No — IF YES, please explain: __________

____

Have you ever had any surgeries? ☐ Yes ☐ No — IF YES, please explain: __________

____

Are you currently experiencing any chronic pain? ☐ Yes ☐ No — IF YES, please explain:

____

Please list all **current** medical conditions/concerns (e.g., high blood pressure, headaches, dizziness, etc.):

____

____

Please list all **past** medical conditions/concerns (e.g., high blood pressure, headaches, dizziness, etc.):

Do you have any allergies? ☐ Yes ☐ No — IF YES, please list:

Have you ever had a hearing exam? ☐ Yes ☐ No | Have you ever had an eye exam? ☐ Yes ☐ No

Please describe any problems discovered from these exams:

Are you **currently** taking any medications? ☐ Yes ☐ No

IF YES, please list the name of medication, dosage, prescribing physician and purpose:

Current Medication	Dosage	Prescribing Physician	Reason for Taking

HEALTH • WELLNESS • LIFESTYLE

How would you rate your current physical health? ☐ Poor ☐ Fair ☐ Good ☐ Very Good

How would you describe your current sleep/rest? ☐ Poor ☐ Fair ☐ Good ☐ Very Good

On average, how many hours of sleep do you receive daily?

Do you have trouble falling asleep at night? ☐ Yes ☐ No

IF YES—please explain:

IF YES—How long has this been a problem?

How would you describe your eating habits overall? ☐ Poor ☐ Fair ☐ Good ☐ Very Good

Describe your appetite (during the past week): ☐ Poor Appetite ☐ Average Appetite ☐ Large Appetite

Please explain:

Do you eat balanced meals regularly? ☐ Yes ☐ No

Do you worry you have lost control over how much you eat? ☐ Yes ☐ No

Would you say that food dominates your life? ☐ Yes ☐ No

Do you make yourself sick because you feel uncomfortably full? ☐ Yes ☐ No

Do you believe yourself to be fat when others say you are too thin? ☐ Yes ☐ No

Have you recently lost more than 15 pounds in a three-month period? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No IF YES—types(s): How often?

CHEMICAL USE AND HISTORY

Do you consume caffeine? ☐ Yes ☐ No IF YES—how much do you consume per day? ______________

Do you currently use alcohol? ☐ Yes ☐ No

IF YES—how often: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely How much (# per time): ______________

Do you currently smoke cigarettes or use tobacco? ☐ Yes ☐ No

IF YES—how much do you smoke / chew (#per day)? ______________

Do you currently use any other drugs? ☐ Yes ☐ No

IF YES—what drugs do you use: ______________

How often: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Have you received any previous treatment for chemical use or alcohol use? ☐ Yes ☐ No

IF YES—where did you go? ______________ When? ______________

What type of treatment? ☐ Inpatient ☐ Outpatient ☐ Other: ______________

Please answer the following by selecting "Yes" or "No:"

Have you ever used more than 1 chemical at the same time to get high? ☐ Yes ☐ No

Do you avoid family activities so you can use drugs or alcohol? ☐ Yes ☐ No

Do you have a group of friends who also use drugs or alcohol? ☐ Yes ☐ No

Do you use drugs or alcohol to improve your emotions such as when you feel sad or depressed? ☐ Yes ☐ No

Does anyone in your immediate family have a history of alcohol/drug abuse? ☐ Yes ☐ No

IF YES—for how long? __________ Please explain: ______________

____

LEGAL ISSUES

Are you currently involved in any legal litigation? ☐ Yes ☐ No

IF YES—please explain: ______________

____

Do you have any prior convictions? ☐ Yes ☐ No IF YES—please list: ______________

____

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

____

____

FAMILY HISTORY

Are your parents married, separated or divorced? ______________

Do you think their relationship is good? ☐ Yes ☐ No ☐ Unsure

If divorced/separated, how old were you at time of divorce/separation? ______________

If your parents are divorced, whom do you primarily live with? ______________

How often do you see each parent? | Mom ______ % Dad ______ %

Did you experience any abuse as a child in or outside of your home (physical, verbal, emotional, or sexual)? ☐ Yes ☐ No

IF YES—please describe as much as you feel comfortable: ______________

Overall you would describe your family life growing up as (check all that apply):

☐ Supportive ☐ Negative ☐ Loving ☐ Chaotic ☐ Confusing ☐ Affirming ☐ Strict
☐ Hostile ☐ Safe ☐ Unsafe ☐ Positive ☐ Lonely ☐ Fulfilling ☐ Scary

FAMILY RELATIONSHIPS

Please describe your siblings:

Number of brothers: ______ Ages: ______________

Number of sisters: ______ Ages: ______________

Briefly describe your relationship with your brothers and/or sisters:

Biological siblings: ______________

Step and/or half siblings: ______________

Other: ______________

Were you adopted or raised with parents other than biological parents? ☐ Yes ☐ No

IF YES—please explain: ______________

FAMILY CONCERNS *(please check any concerns below that your family is currently experiencing)*

☐ Fighting
☐ Feeling distant
☐ Loss of fun
☐ Lack of honesty
☐ Physical fights
☐ Education problems
☐ Financial problems
☐ Death of a family member
☐ Disagreeing with relatives
☐ Disagreeing about friends
☐ Alcohol use
☐ Drug use
☐ Infidelity (couple)
☐ Divorce/separation
☐ Issues regarding remarriage
☐ Birth of sibling
☐ Abuse/neglect
☐ Inadequate housing
☐ Feeling unsafe
☐ Job change or job dissatisfaction
☐ Birth of a child
☐ Inadequate health insurance

Other: ______________

PEER RELATIONS

How do you consider yourself socially? ☐ Outgoing/Extrovert ☐ Shy/Introvert ☐ Depends on the situation

Are you happy with the amount of friends you have? ☐ Yes ☐ No | IF NO—please explain:

Have you ever been bullied or taken advantage of by someone? ☐ Yes ☐ No

IF YES—please explain: ____

Are your parents happy with your friends? ☐ Yes ☐ No | IF NO—please explain:

Are you involved in any organized social activities (e.g. sports, clubs, music)? ☐ Yes ☐ No

IF YES—please list: ____

Have you ever had a boyfriend or girlfriend? ☐ Yes ☐ No

IF YES—how many relationship have you had? ____________________

Are you currently in a relationship? ☐ Yes ☐ No | IF YES—for how long? ____________________

Please describe your sexual orientation:

☐ Heterosexual / straight ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Queer ☐ Questioning / not sure

Are you sexually active? ☐ Yes ☐ No | IF YES—how many partners have you had? _______________

IF YES—is your current sexual partner(s) (check all that apply):

☐ Male ☐ Female ☐ Transgender: Male-To-Female ☐ Transgender: Female-To-Male ☐ NONE

Do you use protections: ☐ Yes ☐ No

Have you ever had a STD? ☐ Yes ☐ No | IF YES—please explain: ____________________

Do you use the internet to look at pornography? ☐ Yes ☐ No

IF YES—what type? __________________________ How often? _______________

Is this an area of concern for you? ☐ Yes ☐ No | IF YES—please explain: ____________________

If female, have you ever been pregnant? ☐ Yes ☐ No | IF YES—how many pregnancies? __________

IF YES—what was the outcome of each pregnancy? __________________________

Have you ever exchanged sex for money, food, shelter or drugs? ☐ Yes ☐ No

IF YES—please explain: ____

Have you ever been hurt (physically or sexually) by someone you are close to or involved with, or by a stranger? ☐ Yes ☐ No | IF YES—please explain:

Are you currently being hurt by someone you are close to or involved with? ☐ Yes ☐ No

IF YES—please explain:

Do you feel safe at home? ☐ Yes ☐ No | IF NO—please explain:

SCHOOL HISTORY

Do you like school? ☐ Yes ☐ No | Please explain:

Do you attend regularly? ☐ Yes ☐ No | Please explain:

Do you have a favorite subject? ☐ Yes ☐ No | Please explain:

Do you feel you are doing the best you can at school? ☐ Yes ☐ No | Please explain:

Do you have a diagnosed learning disability? ☐ Yes ☐ No

IF YES—please describe:

SPIRITUAL HISTORY

What spiritual tradition where you raised in, if any?

Do you currently practice a spiritual tradition? ☐ Yes ☐ No

IF YES—please describe:

How does your spirituality affect your life in general and/or daily life?

Are your spiritual beliefs: ☐ Helpful ☐ A Hindrance

Please explain:

Will your spiritual beliefs be an important part of counseling? ☐ Yes ☐ No

Please explain:

EMPLOYMENT HISTORY

Have you ever had a job? ☐ Yes ☐ No | IF YES—beginning with your most recent first, please list the jobs or positions you have held:

____

____

____

Are you currently working? ☐ Yes ☐ No

IF YES—how satisfied are you with your current employment situation?

☐ Unsatisfied ☐ Moderately Satisfied ☐ Very Satisfied

Please explain: ______________________________

____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try? ______________________________

____

____

Who and what are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? Please describe:

____

____

INDIVIDUAL CONCERNS *(please identify your current concerns and their severity*

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
Acting without thinking					Body image issues				
Alcohol use					Bulimia				
Anger issues					Compulsive eating				
Angry mood					Crying/tearful				
Anorexia					Cutting				
Appetite changes					Day wetting				
Argumentative					Delinquency				
Arrests					Dieting				
Avoidance of responsibility					Difficulty concentrating				
Bed wetting					Difficulty sleeping				
Binging/purging					Disorganized				
Blames others					Drug use				
Elevated mood					Indecisiveness				
Exaggerated sense of worth					Internet relationship(s)				

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
Excessive worry					Irritability				
Excessive exercise					Lack of confidence				
Exposure to traumatic event					Loneliness				
Extreme shyness					Lots of energy				
Fatigue/easily tired					Low energy				
Feeling panicky					Low self-worth				
Fire setting					Lying				
Frequent conflicts					Mood swings				
Frequent physical complaints					Muscle tension				
Grief					Nausea/indigestion				
Hair pulling					Nightmares				
Hallucinations					Not interested in things				
Hard to remember things					Interrupting others				
Harming others					Panic attacks				
Hear or see things other do not					Paranoid thoughts				
Helplessness					Past suicide attempts				
Hopelessness					Phobias				
Hurting animals					Poor decisions				
Hurting self					Pornography				
Hyperactivity					Pre-occupation with sex				
Impulsivity					Prescription drug abuse				

We would like you to know that we respect your privacy and hope to create an atmosphere where you feel comfortable and safe in sharing. Thank you for taking the time to complete this form and for your honesty.

My signature below confirms that I have done my absolute best to answer the following questions honestly and completely.

PRINTED NAME

SIGNATURE

DATE